



## PATIENT REGISTRATION

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State & Zip \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Primary Language \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Employer/Occupation \_\_\_\_\_

Spouse's Name & Birthdate \_\_\_\_\_ Martial Status \_\_\_\_\_

Emergency Contact & Phone Number \_\_\_\_\_

Referring Physician \_\_\_\_\_

Family Physician \_\_\_\_\_

Pharmacy Name & Address \_\_\_\_\_

Consent to import medications directly from the pharmacy (SureScripts)  YES  NO

Do you see any other specialists regularly (*cardiologist, pulmonologist, neurologist*)? Is so, list each provider by name here:

Specialty: \_\_\_\_\_ Physician Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Physician Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Physician Name: \_\_\_\_\_

Do you have any current testing or procedures pending? \_\_\_\_\_

Please list any allergies : \_\_\_\_\_

Has anyone in your family been diagnosed with Colon Cancer?  YES  NO

If yes, whom and what age were they diagnosed? \_\_\_\_\_

Has anyone in your immediate family been diagnosed with colon polyps?  YES  NO

Prior to arriving, please review our patient rights and responsibilities at

<https://usdigestivehealth.com/privacy-policy/>

*Paper copies are available upon request*

Patient Name & DOB \_\_\_\_\_

Check if you have a history of:

Check if you are experiencing any of these symptoms:

Abnormal Liver Tests	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>
Anal Fissure	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Bloating/Belching	<input type="checkbox"/>
Arrhythmia	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Nausea	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	Regurgitation	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	Change in Bowel Habits	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Black, Tarry Stools	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	Recent Weight Change	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Bleeding/Bruising	<input type="checkbox"/>
Gall Stones	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	Fever	<input type="checkbox"/>
Gastro Esophageal Reflux	<input type="checkbox"/>	Blurred or Double Vision	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Ear Ringing	<input type="checkbox"/>
Heart Valve	<input type="checkbox"/>	Mouth Sores	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	Swelling of Ankles	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Cough	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	Rash/Itching	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	Confusion	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Feeling of Depression	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	Feeling of Anxiety	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>		
OTHER: _____		OTHER: _____	





## Consent to Treat/Assignment of Benefits

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand and agree that Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health may provide treatment to me and may use and disclose protected health information about me for treatment, payment and/or health care operations.

I authorize the release of any medical information necessary to process my claims to the insurance companies/carriers listed in my file. I authorize and assign payment of medical benefits on my behalf directly to Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health. A copy of this authorization will be as valid as the original.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

# Informed Consent for Telemedicine Services

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## About Telemedicine:

Telemedicine involves the use of electronic communication technologies by a health care provider to deliver health care services to a patient when the patient and provider are at different locations.

## I understand the following:

- Telemedicine visits are generally not recorded, and video, audio, or images are not electronically stored. My provider will obtain my authorization to record if he/she recommends recording the visit for my record.
- Laws that protect privacy and confidentiality of medical information also apply to telemedicine.
- The doctor may bill my health care insurance for telemedicine services, and I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.
- I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without jeopardizing access to other available services or affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by advising my health care provider. As long as I do not revoke my consent, my health care provider may provide healthcare services to me via telemedicine without the need to sign a consent for each telemedicine encounter.
- Electronic systems used will incorporate security protocols, in accordance with Federal law, to protect the confidentiality of patient identification and information and will include measures to safeguard against electronic interception of the communication, however no guarantees have been provided.

**Benefits:** Potential benefits of telemedicine include improved access to health care.

**Risks:** I understand that there are potential risks associated with the use of technology for telemedicine services, including but not limited to:

- The video connection may not work, or may stop working during the telemedicine visit;
- The video or sound may not be clear enough to be useful to effectively complete the telemedicine visit;
- I may need to reschedule an in-person visit if the health care provider believes the information able to be obtained during the telemedicine visit is not sufficient;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- Security protocols could fail, causing a breach of privacy of personal medical information.

<b><u>Certification of Patient:</u></b>	<b><u>Certification of Health Care Provider:</u></b>
<p>By signing below, I certify that I have been instructed on accessing telemedicine services and have had an opportunity to ask the health care provider all my questions concerning anticipated benefits, and potential risks, and all of my questions have been answered to my satisfaction. I hereby consent to having my health care provider provide health care services to me via telemedicine and accept any associated risks.</p> <p>_____ Patient Signature or Authorized Individual      Date      Time</p> <p>_____ Printed Name of Authorized Individual</p> <p><u>Role of Authorized Individual:</u> <input type="checkbox"/> Parent   <input type="checkbox"/> POA/Legal Guardian   <input type="checkbox"/> Other: _____</p>	<p>I hereby certify that I have discussed with the individual granting consent, anticipated benefits, potential risks, and additional information described in this consent.</p> <p><b><i>NOTE: If verbal consent is obtained in lieu of the patient's written informed consent, complete VERBAL CONSENT CERTIFICATION section.</i></b></p> <p>_____ Signature of Licensed Health Care Provider</p> <p>_____ Date      Time</p>



**HIPAA Contact Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may contact me by mail at my address on record Yes  No

You may contact me by phone at my contact number on record Yes  No

You may leave a message on my contact number on record Yes  No

You may contact me/leave a message at the following number: \_\_\_\_\_

You may discuss my healthcare needs/release necessary medical information with family and/or others involved in my care as listed below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that I will receive my clinical visit summary as well as any orders via my home address on file.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient



## Financial Policy

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Thank you for choosing Regional Gastroenterology Associates of Lancaster, d/b/a U.S. Digestive Health (USDH). USDH is committed to providing you with the best care possible, while minimizing your out-of-pocket expenses and making the payment of any private balances as easy as possible. In order to do this, our financial department will need your assistance and your understanding of our financial policy. Please read and sign this Financial Policy prior to your treatment.

We participate with most major insurance plans, including Medicare. If you are not insured by a plan with which we participate, payment in full is expected at each visit. If you are insured by a plan in which we participate, but you do not provide up-to-date insurance information, you will be considered self-pay until insurance coverage can be confirmed. It is your responsibility to know your insurance benefits. Please contact your insurance company with any coverage questions.

All patients must complete our patient registration process before seeing the physician or provider. We will need a copy of your identification card and a current valid health insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

### **Insurance:**

For your convenience we will submit claims to your insurance carrier for payment provided we are contracted with your chosen insurance. We will submit to primary, secondary and supplemental plans as needed.

It is your responsibility to provide USDH with current, accurate billing information at the time of your visit and to notify us of any changes in the information. If the information provided is inaccurate or inactive, you will be considered self-pay for services.

Co-payments are due at the time services are provided. This is a contractual agreement you have with your health plan and our contractual obligation with participating insurance carriers. If payments are not made at time of service, there may be a Co-Pay Billing Fee. USDH accepts cash, checks, debit cards and major credit cards. Returned checks are subject to a reasonable processing fee.

### **Referrals:**

It is your responsibility to determine if you require a referral before your appointment. If you arrive without a referral and one is needed, you may be asked to either pay for your appointment in full before being seen or to reschedule your appointment pending the referral.

**Pre-Authorizations:**

USDH will obtain precertification for any services that require pre-authorization. Pre-authorization does not guarantee that the service will be covered or paid by your insurance carrier. Precertification is the process of notifying the insurance carrier of certain treatment services you will receive so the insurance carrier can determine medical necessity.

Our relationship is with the patient, not the insurance carrier. While pre-authorizations, referrals and the filing of insurance claims is a courtesy extended to our patients, all charges are your responsibility. If you disagree with a bill from our office, please contact your insurance company as the first step to determine the reason for any balance or non-coverage of a service. It is the patient’s responsibility to contact their insurance carrier prior to treatment and service to determine specific guidelines for coverage, deductibles and co-pays based on your individual coverage.

**Self-Pay:**

You are expected to pay a minimum deposit of \$65.00 for all office visits which will be applied to your total charge for services that day. Self-Pay discounts are offered and applied to your balance. Remaining balances paid within 30 days of the date of service are eligible for an additional prompt payment discount. If at any time you are unable to pay a balance due, please contact our office for assistance or to establish a payment plan.

**Balances:**

You have a financial responsibility to pay for any services received at USDH. This includes co-pays, co-insurance, deductibles, non-covered services and self-pay fees. Please understand that that if payment or a payment plan is not established after issuance of three statements, the balance on the account may be placed with a collection agency. Reasonable costs associated with collection efforts will be your responsibility.

I understand that I am financially responsible for any co-pays, co-insurance, deductibles, non-covered services and self-pay fees. I have read and understand this Financial Policy and by signing I accept all terms and conditions described above.

**No Show and Cancellation Policy:**

Last minute cancellations and no-shows prevent other patients from receiving necessary treatment and creates an added expense for the Practice and physician. To promote efficient access to our services, we request that you notify us at least 24 hours in advance if you cannot keep your appointment. In the event that an appointment is missed or cancelled with less than 24- hour notice, a \$25.00 charge will be billed to your account.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

Relationship to Patient: \_\_\_\_\_





**Notice of Privacy Practices Acknowledgement**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for treatment, payment and healthcare operations.

By signing this form, I acknowledge that I have viewed and have been offered a copy of U.S. Digestive Health’s “Notice of Privacy Practices” (“NPP”). This NPP describes in detail how we might use or disclose your protected health information.

I understand that this organization has the right to change its NPP from time to time and I may request a copy of the NPP at any time or review it on the company website.

I am aware that I may request a copy of the NPP at any time and that a current version of the NPP is available at [www.USDigestiveHealth.com](http://www.USDigestiveHealth.com) under “Privacy Policy”.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

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*If Applicable*

The patient refused or was unable to acknowledge the Notice of Privacy Practices (please indicate reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Staff Representative Signature

\_\_\_\_\_  
Date



## Non-Discrimination Notice

U.S. Digestive Health (USDH) and its affiliates comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. USDH does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender, sexual orientation or gender identity. We provide free aids and services to people with disabilities to communicate effectively including:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Practice Administrator for this location.

If you believe that USDH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

U.S. Digestive Health  
Privacy Officer  
707 Eagleview Blvd, Suite 100  
Exton, PA 19341  
Email: [Compliance@usdhealth.com](mailto:Compliance@usdhealth.com)  
Phone: 610-234-7922

You can file a grievance in person or by mail, email or telephone. If you need help filing a grievance, the Practice Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.  
or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Spanish** - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al 1-215-257-5071 (TTY: 711)

**Chinese** - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-215-257-5071 (TTY: 711)

**Vietnamese** - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-215-257-5071 (TTY: 711)

**Russian** - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-215-257-5071 (телетайп: 711).

**Pennsylvania Dutch** - Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannst du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-215-257-5071 (TTY: 711).

**Korean** - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-215-257-5071 (TTY: 711)번으로 전화해 주십시오.

**Italian** - ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-215-257-5071 (TTY: 711).

#### **Arabic**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-215-257-5071-1 (رقم Arab هاتف الصم و-711).

**French** - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-215-257-5071 (ATS : 711).

**German** - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-215-257-5071 (TTY: 711).

**Gujarati** - સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-215-257-5071 (TTY: 711).

**Polish** - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-215-257-5071 (TTY: 711).

**French Creole** - ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-215-257-5071 (TTY:711).

**Cambodian** - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-215-257-5071 (TTY: 711)។

**Portuguese** - ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-215-257-5071 (TTY: 711).



## Your Rights and Protections Against Surprise Medical Bills

**When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.**

### **What is “balance billing” (sometimes called “surprise billing”)?**

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

### **You are protected from balance billing for:**

#### **Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility**

## in your plan's network.

Pennsylvania also provides partial balance billing protections to limit billing amounts to in-network cost sharing amounts for emergency services and most health care professionals.

### When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, you may contact either the location at which the services were provided or our toll-free billing customer service line at 1-877-543-9753. You may also contact our Compliance Department by email at [Compliance@usdhealth.com](mailto:Compliance@usdhealth.com) or call the USDH corporate office at 610-234-7900 for assistance.

Visit [No Surprises: Understand your rights against surprise medical bills | CMS](#) for more information about your rights under federal law.

Visit [Regular Session 2019-2020 Senate Bill 0822 P.N. 1128 \(state.pa.us\)](#) for more information about your rights under [state laws].]